



NY Council Non Profits 10002133

Association PPO Plan Benefit Summary
PPOASSOC10

	In -Network
Embedded Deductible (Single/Family)	\$500/\$1,250
Coinsurance	20%
Office Visits	
PCP	\$35 Per Visit. Not subject to deductible.
Specialist	\$35 Per Visit. Not subject to deductible.
Coinsurance Maximum (Single/Family)	\$2,000/\$5,000
Annual Benefit Maximum	\$1,000,000
Physician Services	
PCP Office Visits for illness, injury or second opinion	\$35 Per Visit. Not subject to deductible.
Specialist Office Visits for illness, injury or second opinion	\$35 Per Visit. Not subject to deductible.
Physician Visits during inpatient stay when billed separately from the facility	Deductible then Covered in Full
Well Baby and Child Care including immunizations and inoculations	Covered In Full
Annual Adult Exam	\$35 Per Visit. Not subject to deductible.
Annual Gynecological Exam	\$35 Per Visit. Not subject to deductible.
Hospitals Services	
Inpatient Hospital (semi-private room, anesthesia, X-Ray, lab tests, etc)	Deductible then 20% Coinsurance
Outpatient Surgery	Deductible then 20% Coinsurance
Diagnostic Testing*	
Outpatient Hospital Laboratory Services: Copayment/coinsurance waived if provider is a designated laboratory	\$35 Copayment. Not subject to deductible.
Outpatient Hospital Radiology Services: Copayment/coinsurance waived if provider is a preferred center	\$35 Copayment. Not subject to deductible.
Office Based Laboratory Services: Copayment waived if provider is a designated laboratory	\$35 Copayment. Not subject to deductible.
Office Based Radiology Services: Copayment/coinsurance waived if provider is a preferred center	\$35 Copayment. Not subject to deductible.
Mammogram	\$35 Copayment. Not subject to deductible.
Cytology Screening	\$35 Copayment. Not subject to deductible.
Prostate Cancer Screening	\$35 Copayment. Not subject to deductible.
Maternity	
Physician Services when billed separately from the facility	Deductible Then Covered in Full
Inpatient Hospital Services	Deductible Then 20 % Coinsurance
Newborn Nursery	Deductible Then Covered in Full
Emergency Care	
Worldwide Emergency Room Care	Deductible Then 20% Coinsurance
Ambulance	Deductible then 20% Coinsurance
Urgent Care	
Nonparticipating Urgent Care facility services within the CDPHP UBI service area are not covered	\$45 copayment. Not subject to deductible
Physical Therapy	
Up to 30 visits per benefit period. In network and Out Of Network Visits are counted toward the maximum	\$35 copayment. Not subject to deductible
Speech Therapy	
Up to 20 visits per benefit period. In network and Out Of Network Visits are counted toward the maximum	Not Covered
Occupational Therapy	
Up to 30 visits per benefit period. In network and Out Of Network Visits are counted toward the maximum	\$35 copayment. Not subject to deductible
Chiropractic Benefits	\$35 copayment. Not subject to deductible
Home Health Care	Deductible (\$50) Then 20% Coinsurance
Skilled Nursing Facility - Up to 365 days per benefit period	Not Applicable



Prosthetic Appliances and Durable Medical Equipment	50% Coinsurance. Not subject to deductible. Limited to \$25k per lifetime
Diabetic Services	
Insulin and oral Medication - up to a 30 day supply	
Diabetic Supplies (needles and syringes) - up to a 30 day supply	\$15 Copayment
Glucometers	\$15 Copayment
Diabetic DME	\$15 Copayment
Mental Health Services	
Outpatient Services - Up to 20 visits per benefit period. For groups with greater than 50 employees, see Federal Mental Health Parity Amendment.	\$35 copayment. Not subject to deductible
Inpatient Services - Up to 30 days per benefit. For groups with greater than 50 employees, see Federal Mental Health Parity Amendment.	Deductible then 20% Coinsurance
Chemical Abuse and Dependency Services	
Outpatient Services - Up to 60 visits per calendar year. For groups with greater than 50 employees, see Federal Mental Health Parity Amendment.	\$35 copayment. Not subject to deductible
Inpatient Services - Up to 7 days per benefit period. For groups with greater than 50 employees, see Federal Mental Health Parity Amendment.	Not Covered
Inpatient Rehabilitation Services - Not covered. For groups with greater than 50 employees, see Federal Mental Health Parity Amendment.	Not Covered
Dependent Coverage	Extends eligibility to full time student until age 25
LifePoints Participation	Not Participating

This Summary of Benefits is intended to provide a general outline of coverage that is pending approval with the New York State Department of Insurance. It is not binding on CDPHP in the event the proposed product is not approved by the DOI. In the event of any conflict between this document, the member's Certificate and any applicable Rider(s) issued by CDPHP, the Certificate and Rider(s) will be the controlling documents.

CDPHP gives you access to more than 8,000 participating practitioners and providers, many of the major hospitals, and a variety of value-added services to help you and your family stay healthy. If you have a question or wish to receive additional information, please contact the CDPHP Marketing department at (518) 641-5000 or 1-800-993-7299 or visit our website at www.cdphp.com.

*Please visit our website at www.cdphp.com or contact CDPHP UBI Member Services at (518) 641-3140 or 1-877-269-2134 to identify designated laboratories and preferred radiology sites.

All benefits of this plan are subject to coordination of benefits. This summary is designed to highlight benefits of the plan being offered and does not detail all benefits, limitations, or exclusions. It is not a contract and may be subject to change. For more detailed information, a membership certificate is available for your review upon request.

Please Note: All non-emergency services must be provided by a CDPHP Universal Benefits, Inc. (CDPHP UBI) Participating Physician/provider (including hospital admissions) unless otherwise preauthorized by CDPHP UBI.



**NY Council Non Profits
Group Number 10002133**

Your employer has chosen the following rider(s) to modify the Plan under which you would be covered as a CDPHP Member.

PPRXS12A10

Prescription drug benefits as follows: * \$4 copayment for 30-day supply of covered Tier 1 drugs.* \$30 copayment for 30-day supply of covered Tier 2 drugs.* \$60 copayment for 30-day supply of Tier 3 drugs.* Mail order: 2.5 copayments for a 90-day supply.* Prescriptions must be written by a duly licensed health care provider and filled at a participating pharmacy, unless otherwise authorized in advance by CDPHP.* Specialty drugs require preauthorization and must be obtained at CDPHP's participating specialty vendors.* Prescription drug benefit is capped at \$2,000 per benefit period.

PPELGS310

Extends eligibility to full-time student dependents until age 25.

PPELGS1210

Provides coverage for an eligible same or opposite sex domestic partner and his or her eligible dependent children.

PPBHS110

Federal Parity - Unlimited Inpatient and Outpatient Mental Health and Chemical Abuse Services

PPVSNS210

One routine eye exam is covered every 24 months, commencing on the group effective date, without referral, subject to a visit copayment.

PPSNFS110

Extends skilled nursing facility benefit to 365 days per benefit period.